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# The likely implications of the 1997 Coroners Ordinance on the autopsy service of a teaching hospital

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The new Hong Kong Coroners Ordinance was published in April 1997. It introduced an expanded set of guidelines for reporting deaths to the coroner as well as the threat of criminal proceedings for non-compliance. The Ordinance is due to be implemented in early 1998. The aim of this study is to determine the likely effect of the new law on the relative proportion of coroner's and hospital (consent) autopsies. A total of 352 consecutive autopsy cases were reviewed; 170 (48.3%) were referred for coroner's autopsies and 182 (51.7%) for hospital autopsies. By applying the criteria of the current ordinance, there should have been 213 (60.5%) coroner's autopsies and 139 (39.5%) hospital autopsies—that is, 43 hospital autopsies should have been coroner's autopsies. Under the new Coroners Ordinance, there would be 300 (85.2%) coroner's autopsies and only 52 (14.8%) hospital autopsies. The new Coroners Ordinance is likely to result in a greater number of requests for coroner's autopsies with a corresponding decline in hospital autopsies—in our case, a shift from 48.3% of all autopsies performed to 85.2%! This increase would be due largely to the requirement for reporting stillbirths but would also be due to increased reporting for fear of 'criminal proceedings' for non-compliance. An absolute increase in the number of autopsies is also anticipated, although the magnitude cannot as yet be predicted.

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*Key words: Autopsy; Coroners and medical examiners; Hong Kong; Medical audit; Practice guidelines; Professional practice*

## Introduction

The new Coroners Ordinance<sup>1</sup> was published in April 1997 after a long delay. The changes were proposed more than 10 years ago. With its impending implementation in early 1998, this study seeks to highlight some of the major changes that will affect the reporting of deaths to the coroner in the setting of a teaching hospital.

The existing Coroners Ordinance<sup>2</sup> has been in force since 1967, albeit with a number of minor amendments.

Under these rules, a death must be reported when: the death is sudden; the death occurs in suspicious circumstances; the death is accidental; a dead body is found in Hong Kong; and a dead body is brought into Hong Kong. It has been frequently observed that there is inherent ambiguity in these guidelines, especially concerning what constitutes 'sudden death'. It is not uncommon to find that clinicians and pathologists have markedly different interpretations of which cases need to be reported to the coroner.

Much of the ambiguity of the requirements for reporting a death to the coroner has been removed under the new Coroners Ordinance. This new ordinance lists in Schedule 1, Part 1, 20 situations whereby deaths are to be reported to the coroner. These are reproduced here as we believe it is important that all practising doctors be aware of them.

- (1) Any death of a person where a registered medical practitioner is unable to accurately state the medical cause of death in the death certificate.

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- (2) Any death of a person (excluding a person who, before their death, was diagnosed as having a terminal illness) where no registered medical practitioner has attended the person during their last illness in the 14 days prior to their death.
- (3) Any death of a person where an accident or injury (sustained at any time) caused the death.
- (4) Any death of a person where a crime or suspected crime caused the death.
- (5) Any death of a person where :
  - (a) an anaesthetic caused the death;
  - (b) the person was under the influence of a general anaesthetic at the time of death; or
  - (c) the death occurred within 24 hours of administration of a general anaesthetic.
- (6) Any death of a person where:
  - (a) an operation, whether or not lawful, caused the death; or
  - (b) the death occurred within 48 hours after a major operation (as determined in accordance with prevailing medical practice), whether lawful or not.
- (7) Any death of a person where:
  - (a) an occupational disease, within the meaning of section 3 of the Employees' Compensation Ordinance (Cap. 282), or pneumoconiosis, within the meaning of section 2(1) of the Pneumoconiosis (Compensation) Ordinance (Cap. 360), caused the death; or
  - (b) having regard to the nature of the last illness of the person, the medical cause of the death and the nature of any known occupation or employment, or previous occupation or employment, of the person, it is reasonable to believe that the death may be connected, either directly or indirectly, with any such occupation or employment.
- (8) Any stillbirth where:
  - (a) there is doubt as to whether the stillborn foetus was alive or dead at the time of birth; or
  - (b) there is a suspicion that the stillbirth might not have been a stillbirth but for the wilful act or neglect of any person.
- (9) Any death of a woman where the death occurred within 30 days after:
  - (a) the birth of a child;
  - (b) an operation of abortion, whether lawful or not; or
  - (c) a miscarriage.
- (10) Any death of a person where:
  - (a) septicaemia caused the death; and
  - (b) the primary cause of the septicaemia is unknown.
- (11) Any death of a person where there is a suspicion the death was caused by suicide.
- (12) Any death of a person where the death occurred while the person was in official custody.
- (13) Any death of a person where the death occurred during the course of the discharge of duty by a person having statutory powers of arrest and detention.
- (14) Any death of a person where the death occurred in the premises of a department of the Government, any public officer of which has statutory powers of arrest or detention.
- (15) Any death of a person where the person:
  - (a) was a patient, within the meaning of section 2 of the Mental Health Ordinance (Cap. 136), and the death occurred in a mental hospital within the meaning of that section; or
  - (b) was a patient, the subject of an order under section 31 or 36 of that Ordinance, and the death occurred in a hospital other than such mental hospital.
- (16) Any death of a person where the death occurred in any premises in which the care of persons is carried on for reward or other financial consideration (other than in any premises which comprise a hospital, nursing home or maternity home registered under the Hospitals, Nursing Homes and Maternity Homes Registration Ordinance [Cap. 165]).
- (17) Any death of a person where the death was caused by homicide.
- (18) Any death of a person where the death was caused by the administering of a drug or poison by any other person.
- (19) Any death of a person where ill-treatment, starvation, or neglect caused the death.
- (20) Any death of a person that occurred outside Hong Kong where the body of the person was brought into Hong Kong.

Reporting a death to the coroner is a legal requirement, should a death fall under any of the guidelines given above. However, this action does not necessarily lead to an autopsy. The power to order an autopsy lies with the coroner.

## Materials and methods

The autopsy requests made by clinicians on all autopsies performed at the Queen Mary Hospital during 1996 were retrieved and analysed. For each case, the patient's history and the reason(s) for the autopsy request were examined. Of the 365 autopsies performed, 183 were coroner's autopsies and 182 were hospital autopsies. The latter are autopsies performed with the consent of the next-of-kin with the aim of improving medical knowledge and where the cause of death is thought to be known. The cases were then

**Table 1. Summary of the frequency of reasons for requesting coroner's autopsies**

Reason for requesting a coroner's autopsy	No. of cases (%)
Unnatural/accidental/traumatic death	54 (31.8)
Procedure-related death	32 (18.8)
Sudden death (death within 24 hours of admission)	36 (21.2)
Cause of death not known	47 (27.6)
Dead body brought back into Hong Kong	1 (0.6)
Total	170

**Table 2. Summary of clinical autopsies that should have been reported under the 1967 Coroners Ordinance**

Reason for query	No. of cases (%)
Sudden death*	36 (83.7)
Accidental death†	1 (2.3)
Death within 24 hours of admission	6 (14.0)
Total	43

\* Where the cause of death is unknown or death is reported as 'sudden'

† Hypersensitivity reaction to hospital-administered drug

**Table 3. Summary of clinical autopsies that would be reportable applying the 1997 Coroners Ordinance**

Criterion	No. of cases (%)
Stillbirth	80 (61.5)*†
Inability to accurately state the cause of death	36 (27.7)
Occupational disease	1 (0.8)*
Septicaemia	6 (4.6)*
Death by drug or poison administered by another person	1 (0.8)
Death within 24 hours of admission ('sudden death')	6 (4.6)
Total	130

\* These cases became reportable using the 1997 Coroners Ordinance

† The number here may not be as high once clinicians are comfortable with the requirements under the new ordinance

classified again using first the requirements of the current legislation and then using the requirements of the new Coroners Ordinance.

## Results and discussion

Of the 183 coroner's autopsies, 13 records could not be located. Of the 170 records reviewed, the reasons for reporting the death to the coroner are summarised in Table 1.

The Queen Mary Hospital has adopted a policy of classifying deaths within 24 hours of admission as 'sudden death'. When the existing Coroners Ordinance was used to examine the records of the 182 cases of clinical autopsies, it was found that 43 deaths (24%) were reportable. The reasons are summarised in Table 2. None of the coroner's autopsies had to be reclassified as clinical autopsies. Under the new Coroners Ordinance, of these same 182 clinical

autopsies, many more cases (130; 71.4%) would become reportable. The reasons why these deaths would be reportable are summarised in Table 3. The change in ratio of clinical and coroner's autopsies when existing and new guidelines are applied to the 1996 data is shown in Table 4.

The results of this study indicate that 170 (48.3%) of the total number of autopsies performed at the Queen Mary Hospital in 1996 were coroner's autopsies. If all the rules of the existing 1967 Coroners Ordinance were followed correctly, this figure would be 213 (60.5%). Alarming, this means that 43 of 182 hospital cases should have been done as coroner's cases. This equates to a 23.6% error in the requests for clinical autopsies and suggests that the requirements of the 1967 Coroners Ordinance were either misunderstood or not followed.

The majority of the non-reported cases were those

**Table 4. Summary of the distribution of clinical and Coroner's autopsies if existing and new guidelines are applied to the 1996 data**

Details	No. of clinical autopsies (%)	No. of Coroner's autopsies (%)
From 1996 data	182 (51.7)	170 (48.3)
If all guidelines of 1967 Ordinance were followed	139 (39.5)	213 (60.5)
If the 1997 Ordinance rules were applied	52 (14.8)	300 (85.2)

where the clinician could not accurately state the cause of death. The other main reason for mistaken non-reporting was 'sudden death'—that is, a death within 24 hours of admission.

When the reporting criteria of the 1997 Coroners Ordinance were applied to the data, the percentage of reportable autopsies showed a marked increase to 85.2% of all autopsies. This is an increase of 76% from the current situation. This is due to the new requirements to report cases of stillbirth and septicaemia. The effect of the stillbirth requirement, however, will be rapidly reduced once it is clear that the coroner's interest is only where there is a suspicion of foul play or where there is uncertainty as to whether a baby was born alive or dead. The effects of many of the other requirements such as '48 hours after surgery' could not be tested as the information on the time of surgery is seldom recorded.

The introduction of the new Coroners Ordinance has worried pathologists that a dramatic increase in workload will ensue. Our data show that in hospitals, the changes will create an increase in the proportion of coroner's autopsies versus hospital autopsies. However, we feel certain that there will also be an absolute increase in the total number of autopsies although the magnitude is difficult to predict. This certainty stems from the fact that there are new areas where reporting to the coroner is required, such as deaths in the many privately-run elderly care homes. Many chronically ill, but not terminal, patients are currently being 'certified' by their doctors. The new ordinance would now make such cases reportable where the patients have not been seen in the 14 days prior to death. The period between death and surgery/anaesthesia where reporting is necessary has also been lengthened and we believe this will also result in more deaths being reported. Furthermore, the requirement that all deaths no matter how remotely related to or initiated by an accidental cause be reported, will mean that many patients who die after

months of hospital care, following a fall for example, must now be reported.

The threat of a fine or custodial sentence for non-reporting may also initially cause an increase in reportable deaths. We believe this will quickly return to a stable number once the requirements are better understood. This figure is, however, still likely to be much higher than the current numbers. In this respect, the authorities will have to review their requirements for human resources, as the increased autopsy load is likely to be one that most hospital pathology departments will have difficulty accommodating.

There is an urgent need to further educate clinicians about reporting cases to the coroner, especially with the imminent implementation of the new Ordinance. With this Ordinance, the categorization of reasons for reporting deaths are more precise. Hopefully, this will lead to a situation where there is minimal non-reporting of reportable deaths to the coroner. We believe that the threat of heavy fines and even imprisonment for non-compliance with the new Ordinance will encourage greater compliance. From a medicolegal and clinical audit perspective, the change can only be for the better, but pathology departments should be provided with the appropriate human resources to perform the increased numbers of autopsies.

### Addendum

Since the submission of this manuscript, the date of implementation of the new Coroners Ordinance had been delayed for administrative reasons, and finally came into effect on 4 May 1998.

### References

1. Coroners Ordinance, Ordinance No. 27 of 1997. Hong Kong: Government Printers, 1997.
2. Coroners Ordinance, Chapter 14, Laws of Hong Kong. Hong Kong: Government Printers, 1971.